HOME HEALTH CARE SERVICES

Home health care agencies will be reimbursed for covered services provided to Medicaid recipients through standard, statewide rates, computed as follows:

(1) the overhead cost rate; plus
(2) the staffing rate multiplied by the number of hours spent in the performance of billable patient care activities;

to equal the total reimbursement per visit.

THE OVERHEAD COST RATE is a flate, statewide rate, based on the statewide weighted median overhead cost per visit. The statewide weighted median overhead cost per visit is derived in the following manner:

(1) Determine for each home health agency total patient-related costs submitted by home health agency providers on forms prescribed the Office, less direct staffing and benefit costs, divided by the total number of home heath agency visits during the Medicaid reporting period for that provider. The result of this calculation is an overhead cost per visit for each home health agency.

(2) Array all home health agency providers in the state in accordance with their overhead cost per visit, from the highest to the lowest cost.

(3) Calculate the cumulative number of Medicaid visits for all agencies.

(4) The statewide weighted median overhead cost per visit is the cost of the agency at the point in the accumulation of visits in which half of the Medicaid visits are provided by higher-cost agencies, and half the Medicaid visits are provided by lower-cost agencies.

THE STAFFING COST RATE is a flat, statewide rate, based on the statewide weighted median direct staffing and benefit costs per hour for each of the following disciplines:

(1) Registered nurse
(2) Licensed practical nurse
(3) Home health aide
(4) Physical therapist
(5) Occupational therapist
(6) Speech pathologist

The statewide weighted median direct staffing and benefit costs per hour is derived in the following manner:

(1) Determine for each home health agency total patient-related direct staffing and benefit costs submitted by home health agency providers on forms prescribed by the Office, divided by the total number of home health agency hours worked during the Medicaid reporting period for that provider for each discipline. The result of this calculation is a staffing cost rate per hour for each home health agency and discipline.

(2) Array all home health agency providers in the state in accordance with their staffing cost rate per hour for each discipline from the highest to the lowest.

(3) Calculate the cumulative number of Medicaid hours by all disciplines for all home health agencies.

(4) The statewide weighted median staffing cost rate per hour for each discipline is the cost of the agency at the point in the accumulation of hours in which half of the Medicaid hours are provided by agencies with higher staffing rates per hour, and half the Medicaid hours are provided by agencies with lower staffing rates per hour.

All home health agencies must keep track of and make available for audit total hours paid and hours paid relating to vacation, holiday, and sick pay for all home health agency personnel.

Medicare-certified home health agency providers are required to submit a Medicaid cost report on forms prescribed by the Office and the most recently filed Medicare cost report. Non-Medicare-certified home health agency providers are required to submit a Medicaid cost report on forms prescribed by the Office and the latest fiscal year end financial statements.

Rate setting shall be prospective, based on the provider's initial or annual cost report for the most recently completed period. In determining prospective allowable costs, each provider's cost from the most recent completed year will be adjusted for inflation using the Health Care Financing Administration Home Health Agency Market Basket. The inflation adjustment shall apply from the midpoint of the initial or annual cost report period to the midpoint of the next expected rate period.

The semi-variable cost will be removed from the overhead cost calculated in accordance with 405 IAC 1-4.2-4(b), and added to the staffing cost calculated in accordance with 405 IAC 1-4.2-4(c), based on hours worked.

Field audits will be conducted yearly on a selected number of home health agencies.

Financial and statistical documentation may be requested by the Office or its contractor. This documentation may include, but is not limited to, the following:

(1) Medicaid cost reports
(2) Medicare cost reports
(3) Statistical data
(4) Financial statements
(5) Other supporting documents deemed necessary by the Office or its rate setting contractor.

Each provider shall submit an annual financial report to the Office not later than one hundred fifty (150) days after the close of the provider's reporting year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within sixty (60) days after the initial certification of the provider. This option may be exercised only one (1) time by a provider. If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider's records and the annual financial report.

Extension of the one hundred fifty (150) day filing period shall not be granted unless the provider substantiates to the Office circumstances that preclude a timely filing. Requests for extensions shall be submitted to the Office, prior to the date due, with a full and complete explanation of the reasons an extension is necessary. The Office shall review the request for an extension and notify the provider of approval or disapproval within ten (10) days of receipt of the request. If the request for extension is disapproved, the report shall be due twenty (20) days from the receipt of the disapproval from the Office.

When an annual financial report is thirty (30) days past due and an extension has not been granted, payment for all Indiana Medicaid claims filed by the provider shall be withheld effective on the first day of the month following the thirtieth (30^{th}) day the annual financial report is past due. Payment shall continue to be withheld until the first day of the month after the delinquent annual financial report is received by the Office. After receipt of the delinquent annual financial report, the dollar amount paid to the provider for the claims that were withheld shall be reduced by ten percent (10%). Reimbursement lost because of the ten percent (10%) penalty cannot be recovered by the provider.

When an annual financial report is sixty (60) days past due and an extension has not been granted, the office shall notify the provider that the provider's participation in the Indiana Medicaid program shall be terminated. The termination shall be effective on the first day of the month following the ninetieth (90^{th}) day the annual financial report is past due, unless the provider submits the delinquent annual financial report before that date.

Failure to submit requested documentation may result in the imposition of the ten percent (10%) and termination penalties described above and sanctions set forth in IC 12-15-22-1.

Retroactive payment will be required when any of the following occur:

(1) A field audit identifies overpayment by Medicaid.
(2) A field audit or investigation determines that Medicaid paid more than other payers for like services provided before September 2, 1993.
(3) The provider knowingly receives overpayment of a Medicaid claim from the Office. In this event, the provider must complete appropriate billing adjustment forms and reimburse the Office in the amount of the overpayment.

NEW RATES set after January 1, 1997, shall be effective on January 1, and shall be annually adjusted thereafter based upon the most recently submitted financial and statistical documentation as filed by all providers of service who billed Medicaid for services provided during the cost report period.

FEDERALLY QUALIFIED HEALTH CENTERS

In accordance with Section 6404 of the Omnibus Budget Reconciliation Act of 1989, Indiana Medicaid will pay 100 percent of the costs that are reasonable and related to the cost of furnishing Federally Qualified Health Center (FQHC) services and will meet the requirements of Section 6303 of the State Medicaid Manual regarding payment for FQHC services.

Indiana reimburses FQHC services at interim reimbursement rates established by the agency, subject to a retrospective cost settlement process. Interim payment will be based upon and cover the reasonable costs of providing services to Medicaid beneficiaries. Such costs are not to exceed the reasonable costs as determined by the applicable Medicare cost reimbursement principles set forth in 42 CFR Part 413.

Reimbursement to nursing facilities for residents who elect to receive Hospice Care:

An additional per diem amount will be paid directly to the hospice provider for room and board of hospice residents receiving routine or continuous care services in a certified nursing facility. In this context, the term "room and board" includes all assistance in the activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervision and assisting in the use of durable medical equipment and prescribed therapies.

The room and board rate will be ninety-five percent (95%) of the lowest per diem reimbursement rate Indiana Medicaid would have paid to the nursing facility for any resident for those dates of service on which the recipient was a resident of that facility.

Medicaid payment to the nursing facility for nursing facility care for the hospice resident is discontinued when the resident makes an election to receive hospice care. Any payment to the nursing facility for furnishing room and board to hospice patients is made by the hospice provider under the terms of its agreement with the nursing facility.

The additional amount for room and board is not available for recipients receiving inpatient respite care or general inpatient care.

TARGETED CASE MANAGEMENT

1. HIV Infected Individuals

Reimbursement for case management services shall be on a fee-for-service basis.

The rate will be established by the Medicaid agency. A survey process will be utilized to establish an equitable rate. Service organizations throughout the State (urban and rural) that currently provide specialized case management services to HIV positive persons will be surveyed. The Medicaid agency will formulate a rate based on the results of this survey process. Organizations surveyed will be limited to those currently providing similar services as defined in this plan and whose case managers possess similar qualifications to those enumerated in Supplement 1 to Attachment 3.1-A, Sect. E.

The unit of service shall be a quarter hour segment.

2. Pregnant Women

Reimbursement for case management services for pregnant women shall be on a fee-for-service basis. The rate shall be established by the Medicaid agency based on actual costs of basic case management services from data collected from pilot projects conducted by the I.U. School of Nursing in urban and rural settings. These projects are providing services similar to those described in this plan and employ case managers possessing similar qualifications to those enumerated in Supplement 1 to Attchment 3.1-A, Sect. E. The cost figures provided by the projects are based on salary and benefits divided by the average amount of time spent providing case management services to each recipient. The average cost per recipient is divided into discrete components of care (i.e., initial assessment, reassessment, postpartum assessment) and reimbursed separately as an incentive to initiate services as early as possible in the pregnancy.

Mileage will be reimbursed at the rate per mile allowed by the State Legislature for State employees.

3. Persons Identified as Seriously Mentally Ill or Seriously Emotionally Disturbed

Payments will be based upon the lower of the provider's submitted charge or the Medicaid maximum allowance for the procedure billed. Maximum allowances are established by the Division of Mental Health based upon a review of like charges by similar providers throughout the State.

TRANSPORTATION

Payment will be based upon the lower of the provider's submitted charge or the maximum allowed rate established by the State for the service billed. Maximum allowed rates are based on an analysis of market rates paid for transportation services in Indiana and in Medicaid Programs in other comparable states. Reimbursement for covered transportation services will be as follows:

Taxi Services: Lower of metered or zoned rate or maximum.

Commercial Ambulatory Services (non-taxis): Base rate + mileage payments beyond a specified number of miles.

Non-Ambulatory Services: Base rate + mileage payments beyond a specified number of miles.

Ambulance Services: Loading fee + mileage payments.

Reimbursement is also available for oxygen used during ambulance transport and waiting time for certain trips.

COMMUNITY MENTAL HEALTH REHABILITATION SERVICES

Payment will be based upon the lower of the provider's submitted charge or the OMPP maximum allowance for the procedure billed. Maximum allowances are established by the Department of Mental Health based upon a review of like charges by similar providers throughout the State.

I. COMMUNITY MENTAL HEALTH REHABILITATION SERVICES

Payment will be based upon the lower of the provider's submitted charge or the SDPW maximum allowance for the procedure billed. Maximum allowances are established by the Department of Mental Health based upon a review of like charges by similar providers throughout the State.

OFFICIAL

DISPROPORTIONATE SHARE HOSPITAL PAYMENTS
OUTPATIENT HOSPITAL SERVICES

I. AUTHORITY

In compliance with Section 1902 (a)(13)(A) of the Act, and specifically the mandates of section 4112 (OBRA 1987), P.L. 100-203, the Indiana Medicaid program adopts the following definitions and methodologies to identify and make payments to hospitals to take into account the situation of such providers which serve a disproportionate number of low-income patients with special needs.

II. DEFINITIONS

(A) "Acute Care Hospital" has the following meaning: "Any institution, place, building, or agency represented and held out to the general public as ready, willing, and able to furnish care, accommodations, facilities, and equipment, for the use, in connection with the services of a physician, of persons who may be suffering from deformity, injury, or disease, or from any other condition, from which medical or surgical services would be appropriate for care, diagnosis, or treatment." The term does not include a state mental health institution or a private psychiatric institution, nor does it include convalescent homes, boarding homes, homes for the aged or freestanding health facilities licensed for long term care such as nursing facilities.

(B) "State Mental Health Institution" has the following meaning: "A state-owned or state-operated institution for the observation, care, treatment, or detention of an individual; and under the administrative control of the department of mental health." This group of providers is commonly referred to as state hospitals.

(C) "Private Psychiatric Institution" has the following meaning: "An acute care inpatient facility, properly licensed for the treatment of persons with mental illness." This group of providers is commonly referred to as private psychiatric hospitals.